Effective October 1, 2017

2017 HCPCS CODE ADDITIONS

Bolded Codes
Bolded codes indicate notation of special billing policy.

Chemotherapy
J9034, J9145, J9176, J9205, J9295, J9325, J9352

J9034
Bendeka® (bendamustine HCl) is indicated for the treatment of patients 18 years of age or older with chronic lymphocytic leukemia (CLL). Bendeka is also indicated for the treatment of patients with indolent B-cell non-Hodgkin lymphoma (NHL) that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for a patient with CLL or indolent B-cell NHL that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen.

One of the following ICD-10-CM diagnosis codes is required on the claim: C82.90 – C82.99, C83.00 – C83.09, C85.80, C85.90 or C91.11. Modifers SA, SB, UD, U7 or 99 are allowed.

J9145
Daratumumab is indicated for the treatment of patients 18 years of age or older with multiple myeloma who have received at least three prior lines of therapy, including a proteasome inhibitor (PI) and an immunomodulatory agent, or who are double-refractory to a PI and an immunomodulatory agent. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for a patient with multiple myeloma.

One of the following ICD-10-CM diagnosis codes is required on the claim: C90.00, C90.01, C90.10 or C90.30. Modifiers SA, SB, UD, U7 or 99 are allowed.

J9176
Elotuzumab is indicated in combination with lenalidomide and dexamethasone for the treatment of patients ages 18 years or older, with multiple myeloma who have received one to three prior therapies. Pre-medicate with dexamethasone, diphenhydramine, ranitidine and acetaminophen. Advise patients that lenalidomide has the potential to cause fetal harm. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for a patient with multiple myeloma who has received one to three prior therapies.

One of the following ICD-10-CM diagnosis codes is required on the claim: C90.00, C90.01, C90.10 or C90.30. Modifiers SA, SB, UD, U7 or 99 are allowed.

J9205
Irinotecan liposome is indicated, in combination with fluorouracil (5-FU) and leucovorin (LV), for the treatment of patients ages 18 years or older with metastatic adenocarcinoma of the pancreas after disease progression following gemcitabine-based therapy. Irinotecan liposome is not indicated as a single agent for the treatment of patients with metastatic adenocarcinoma of the pancreas. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for a patient with metastatic adenocarcinoma of the pancreas after disease progression following gemcitabine-based therapy.

Either ICD-10-CM diagnosis codes C25.4 or C25.9 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.

J9295
Necitumumab is indicated, in combination with gemcitabine and cisplatin, for first-line treatment of patients 18 years of age and older with metastatic squamous non-small cell lung cancer. Necitumumab is not indicated for treatment of non-squamous non-small cell lung cancer. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for a patient with metastatic squamous non-small cell lung cancer.

Either ICD-10-CM diagnosis codes C25.4 or C25.9 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.

J9325
Talimogene laherparepvec is a genetically modified oncolytic viral therapy indicated for the local treatment of unresectable cutaneous, subcutaneous and nodal lesions in patients 18 years of age or older with melanoma recurrent after initial surgery. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for patients with melanoma recurrent after initial surgery.

One of the following ICD-10-CM diagnosis codes is required on the claim: C43.0 – C43.9, C51.0 – C58.0, C60.0 – C60.9, C63.00 – C63.9 or D03.0 – D03.9. Modifiers SA, SB, UD, U7 or 99 are allowed.

J9352
Trabectedin is indicated for the treatment of patients 18 years of age or older with unresectable or metastatic liposarcoma or leiomyosarcoma who received a prior anthracycline-containing regimen. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must document that the patient has unresectable or metastatic liposarcoma or leimysarcoma.

One of the following ICD-10-CM diagnosis codes is required on the claim: C49.0 – C49.9. Modifiers SA, SB, UD, U7 or 99 are allowed.

Home Health

G0493 – G0496

G0493 – G0496
Modifiers SA, SB, U7, 22 and 99 are allowed.

Claims must be billed “By Report.”

Medicine

92242, 93590, 93591, 93592, 96377, 99151 – 99153, 99155 – 99156, 99157, **G0492, G0500, G0508, G0509**

92242
CPT-4 code 92242 is considered a bilateral procedure and is split-billable. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. Modifiers TC, 26, SA, SB, U7 and 99 are allowed.

93590, 93591, 93592
Modifiers U7 and 99 are allowed.

96377
Modifiers SA, SB, UD, U7 and 99 are allowed. Claims must be billed “By Report.”

99151, 99155
CPT-4 codes 99151 and 99155 are restricted to patients 1 year of age or older, and younger than 5 years of age. Modifiers SA, SB or U7 are allowed.

99152
CPT-4 code 99152 is restricted to patients 5 years of age and older. Modifiers SA, SB or U7 are allowed.

99153
Modifiers SA, SB or U7 are allowed.

99156, G0500
CPT-4 codes 99156 and G0500 are restricted to patients 5 years of age and older.

G0492
Modifiers SA, SB, U7, 22 and 99 are allowed.

Claims must be billed "By Report."

G0508, G0509
Modifiers GT or 95 are required.

Pathology

80305 – 80307, 81413, 81414, 81439, 84410, 87483, G0499, G0659

80305
Drug test(s), presumptive, any number of drug classes, any number of devices or procedures capable of being read by direct optical observation only includes sample validation when performed, per date of service is CLIA-waived when performed with a CLIA-waived test kit and must be billed with modifier QW to be recognized as a waived test. Using the modifier QW indicates that the test was performed by a laboratory with a current and appropriate CLIA certificate and a California clinical laboratory Certificate of Registration. CPT-4 code 80305 is not a waived test when billed without modifier QW.

The frequency limit is once per week for any provider. A *Treatment Authorization Request* (TAR) may be submitted to override the frequency limit.

CPT-4 code 80305 is reimbursable for Presumptive Eligibility (PE) services.

80306, 80307
The frequency limit is once per week for any provider. A *Treatment Authorization Request* (TAR) may be submitted to override the frequency limit.

CPT-4 codes 80306 and 80307 are reimbursable for Presumptive Eligibility (PE) services.

81413, 81414
A *Treatment Authorization Request* (TAR) is required. The required TAR must document a copy of the report of the physician-interpreted 12-lead electrocardiogram (ECG) with pattern consistent with or suspicious for prolonged QT interval. The TAR must also have clinical documentation of one or more of the following:

- Torsade de pointes in the absence of drugs known to prolong QT interval
- T-wave alternans
- Notched T-wave in three leads
- Syncope
- Family members with long QT syndrome
- Sudden death in family members less than 30 years of age without defined cause.

CPT-4 codes 81413 and 81414 are also limited to once in a lifetime for any provider. A TAR may override the frequency limit.

81439
CPT-4 code 81439 is limited to once in a lifetime for any provider. It is only reimbursable when billed in conjunction with ICD-10-CM diagnosis codes I42.0 – I42.5 or Z82.41 – Z82.49. A *Treatment Authorization Request* (TAR) may override the frequency limit and required ICD-10-CM diagnosis codes.

84410, 87483
CPT-4 codes 84410 and 87483 are not split-billable and must not be billed with modifiers TC, 26 or 99. Modifiers 33 and 90 are allowed.

G0499
HCPCS code G0499 is billable once a year, per recipient, for any provider.

HCPCS code G0499 may be billed with any ICD-10-CM diagnosis code.

Claims must be billed “By Report.”

G0659
The frequency limit is once per week for any provider. A *Treatment Authorization Request* (TAR) may be submitted to override the frequency limit.

HCPCS code G0659 is reimbursable for Presumptive Eligibility (PE) services.

Claims must be billed “By Report.”

Physician-Administered Drugs (PAD)

J0570, J0883, J0884, J1130, J1942, J2182, J2786, J2840, J7320, J7322, J7342, J8670

J0570
Buprenorphine implant is indicated for the maintenance treatment of opioid dependence in patients 16 years of age or older who have achieved and sustained prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine containing product (that is, doses of no more than 8 mg per day of Subutex® or Suboxone® sublingual tablet or generic equivalent). An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for a patient who is opioid dependent.

One of the following ICD-10-CM diagnosis codes must be used when billing for HCPCS code J0570: F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.93 or F19.20. Modifiers SA, SB, UD, U7 or 99 are allowed. Billing frequency is limited to four buprenorphine implants every six months.

J0883
Argatroban for non-ESRD use is indicated in patients 18 years of age or older for:

- the prophylaxis or treatment of thrombosis in patients with HIT.
- anticoagulant in patients with or at risk for HIT undergoing PCI.

ICD-10-CM diagnosis code D75.82 is required when billing for HCPCS code J0883. Modifiers SA, SB, UD, U7 or 99 are allowed.

J0884
Argatroban for End-Stage Renal Disease (ESRD) on dialysis is indicated in patients 18 years of age or older for the treatment of ESRD. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Supporting documentation must indicate that the patient has ESRD.

One of the following ICD-10-CM diagnosis codes is required on the claim: N17.0 – N17.9, N18.5, N18.6, N18.9 or N19. Modifiers SA, SB, UD, U7 or 99 are allowed.

J1130
Diclofenac is indicated in patients 18 years of age or older for the management of mild to moderate pain and management of moderate to severe pain alone or in combination with opioid analgesics. The maximum dosage is 150 mg per day.

Either ICD-10-CM diagnosis codes J45.50 or J82 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.

J1942
Aripiprazole lauroxil is indicated for the treatment of schizophrenia in patients 18 to 65 years of age. The maximum dosage is 882 mg per month.

One of the following ICD-10-CM diagnosis codes is required on the claim: F20.0, F20.1, F20.2, F20.3, F20.5, F20.89, F20.9 or F29. Modifiers SA, SB, UD, U7 or 99 are allowed.

J2182
Mepolizumab is indicated for the add-on maintenance treatment of patients 12 years of age and older with severe asthma and an eosinophilic phenotype.

One of the following ICD-10-CM diagnosis codes is required on the claim: J45.50, J45.51, J45.52 or J82. Modifiers SA, SB, UD, U7 or 99 are allowed.

J2786
Reslizumab is indicated for add-on maintenance treatment of patients 18 years of age or older with severe asthma with an eosinophilic phenotype. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the treatment is for a patient with severe asthma and with an eosinophilic phenotype.

Either ICD-10-CM diagnosis codes J45.50 or J82 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.

J2840
Sebelipase alfa is indicated for the treatment of patients with a diagnosis of lysosomal acid lipase deficiency (LAL-D).

ICD-10-CM diagnosis code E77.0 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.
J7320
GenVisc 850® (hyaluronan derivative) is indicated for the treatment of pain in osteoarthritis of the knee in patients who have failed to respond adequately to conservative, non-pharmacologic therapy and simple analgesics, such as acetaminophen.

One of the following ICD-10-CM diagnosis codes is required on the claim: M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5 or M17.9. Modifiers SA, SB, UD, U7 or 99 are allowed.

Claims must be billed “By Report.”

J7322
Hymovis® (hyaluronan derivative) is indicated for the treatment of pain in osteoarthritis of the knee in patients who have failed to respond adequately to conservative, non-pharmacologic therapy and simple analgesics, such as acetaminophen.

One of the following ICD-10-CM diagnosis codes is required on the claim: M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5 or M17.9. Modifiers SA, SB, UD, U7 or 99 are allowed.

Claims must be billed “By Report.”

J7342
Ciprofloxacin otic solution is a quinolone antimicrobial indicated for the treatment of acute otitis externa due to susceptible isolates of Pseudomonas aeruginosa or Staphylococcus aureus. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must state that the patient has otitis externus due to susceptible isolates of Pseudomonas aeruginosa or Staphylococcus aureus.

ICD-10-CM diagnosis code H60.20 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed. HCPCS code J7342 is reimbursable for Presumptive Eligibility (PE) services.

J8670
Rolapitant is a substance P/neurokinin 1 (NK1) receptor antagonist indicated in combination with other antiemetic agents in adults 18 years of age or older, for the prevention of delayed nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy, including, but not limited to, highly emetogenic chemotherapy.

ICD-10-CM diagnosis code R11.2 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.

Prosthetics and Orthotics (P&O)

L1851, L1852

L1851
Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf must be billed with modifiers LT or RT. This non-taxable item has a frequency limit of one every five years and has a maximum allowance of $8.41.

L1852
Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf must be billed with modifiers LT or RT. This non-taxable item has a frequency limit of one every five years and has a maximum allowance of $7.34.

Radiology

76706, 77065, 77066, 77067, A9515, A9587, A9588, A9597, A9598

76706
Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm is split-billable with an approved *Treatment Authorization Request* (TAR) and must be billed with modifier TC when billing only for the technical component, and modifier 26 when billing only for the professional component. When billing for both the professional and technical service components, a modifier is neither required nor allowed. Modifiers U7 and 99 are allowed.

Modifier 99 must not be billed in conjunction with modifier 26 or modifier TC. The claim will be denied.

Reimbursement is limited to four per year to any provider for the same recipient. A TAR may be submitted to override the frequency limit.

77065, 77066
Unilateral diagnostic mammography and bilateral diagnostic mammography including computer-aided detection (CAD) when performed, is reimbursable whether or not xeroradiography was used in the examination. CPT-4 codes 77065 and 77066 may be billed with modifiers U7 or 99 as appropriate.

CPT-4 codes 77065 or 77066 are reimbursable if one of the following applies:

- The recipient has distinct signs and symptoms for which a mammogram is indicated; or
- The recipient has a history of breast cancer; or
- The recipient is asymptomatic, but on the basis of the recipient's history and other significant factors in the physician's judgement, a diagnostic mammogram is indicated and appropriate

The frequency limit for CPT-4 code 77065 is two screenings per year. The frequency limit for CPT-4 code 77066 is limited to one screening per year. Any provider is allowed to submit a claim for these two codes with a *Treatment Authorization Request* (TAR) override.

Claims must be billed "By Report."

77067
Screening mammography, bilateral (2-view study of each breast), including computer-aided detection when performed is restricted to a frequency limit of one screening per year, any provider. A *Treatment Authorization Request* (TAR) may override frequency limit. Digital screening mammography (code G0202) and film screening mammography (code 77067) will not be reimbursed in the same year for the same recipient, by any provider. CPT-4 code 77067 may include modifiers U7 or 99 as appropriate.

Claims must be billed "By Report."

A9515, A9587, A9588
Reimbursement is limited to one unit (one study dose).

Modifiers U7 or 99 are allowed.

Claims must be billed "By Report."

A9597, A9598
Modifiers U7 or 99 are allowed.

Claims must be billed "By Report."

Skin Substitutes

Q4166–Q4175

Q4166 – Q4171, Q4173 – Q4175
A *Treatment Authorization Request* (TAR) is required by the physician or podiatrist for reimbursement for treatment for wounds, skin ulcers and burns. Claims must be billed "By Report" with an invoice attached. HCPCS codes Q4166 – Q4175 are reimbursable only when billed in conjunction with CPT-4 codes 15271 – 15278.

Q4172
A *Treatment Authorization Request* (TAR) is required by the physician or podiatrist for reimbursement for treatment for wounds, skin ulcers and burns. HCPCS code Q4172 is reimbursable only when billed in conjunction with CPT-4 codes 15271 – 15278.

Surgery

22853, 22854, 22859, 22867 – 22870, 27197, 27198, 28291, 28295, **31551 – 31554**, 31572 – 31574, 31591, 31592, 33340, **33390, 33391, 36456, 36473, 36474**, 36901 – 36909, 37246 – 37249, 43284, 43285, **58674, 62320 – 62327, 62380**

22853, 22854, 22859
"By Report" CPT-4 code 22899 should be used to bill Medi-Cal for correction of idiopathic scoliosis when CPT-4 codes 22853, 22854 and 22859 do not fully describe the procedure because of modifications to the operative approach.

31551, 31553
CPT-4 codes 31551 and 31553 are reimbursable for recipients 11 years of age or younger.

31552, 31554
CPT-4 codes 31552 and 31554 are reimbursable for recipients 12 years of age or older.

33390, 33391
Reimbursement for a second assistant surgeon is allowed for CPT-4 codes 33390 and 33391. Providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim that the services were rendered by more than one assistant surgeon for the same surgery on the same date.

CPT-4 code 33530, which is a coronary artery bypass or valve re-operation, should be billed in addition to the code for the primary procedure codes 33390, 33391 on the same claim form.

36456
Each intensive care code covers all services rendered by a physician including umbilical catheterization, venipunctures, intubations, blood cultures, blood gas interpretations and delivery/birthing room resuscitation. CPT-4 code 36456 is reimbursable if billed separately. Code 36456 is reimbursable for newborns up to one month old.

The neonatal intensive care form used when billing NICU services is not required.

36473, 36474
A *Treatment Authorization Request* (TAR) is required for reimbursement.

58674
CPT-4 code 58674 is reimbursable for female recipients only.

62320 – 62323
CPT-4 codes 62320 – 62323 are reimbursable only for billing injection, drainage or aspiration procedures for diagnostic or therapeutic services. Anesthesiologists performing these diagnostic and therapeutic services are acting as the primary surgeon and should bill these codes 62320 – 62323 with modifier AG. Codes 62320 – 62323 should not be billed with an anesthesia modifier.

A Certified Registered Nurse Anesthetist (CRNA) performing these services with direct supervision of a physician acting as the primary surgeon should bill these CPT-4 codes with modifier QX.

A CRNA performing these services without direct supervision of a physician should bill codes 62320 – 62323 with modifier QZ.

62324 – 62327
CPT-4 codes 62324 – 62327 are reimbursable only for billing injection, drainage or aspiration procedures for diagnostic or therapeutic services. Anesthesiologists performing these diagnostic and therapeutic services are acting as the primary surgeon and should bill CPT-4 codes 62324 – 62327 with modifier AG. Codes 62324 – 62327 should not be billed with an anesthesia modifier.

A Certified Registered Nurse Anesthetist (CRNA) performing these services with direct supervision of a physician acting as the primary surgeon should bill these CPT-4 codes with modifier QX.

A CRNA performing these services without direct supervision of a physician should bill these CPT-4 codes with modifier QZ.

Codes 62324 – 62327 are separately reimbursable. The test injection of opioid medication (usually morphine) may be reimbursed under codes 62324 – 62327. Codes 62324 – 62327 are reimbursable only if the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or a claim attachment, includes a statement that the epidural line was not used during the surgical procedure, but placed for post-operative management.

62380
Claims must be billed “By Report.”

Vaccines
90682, 90750

90682
CPT-4 code 90682 is reimbursable for Vaccines For Children (VFC) and Presumptive Eligibility (PE) services.

Modifiers SA, SB, SK, SL, UD, U7 or 99 are allowed.

The service is a Medicare non-covered service.

Claims must be billed “By Report.”

90750
CPT-4 code 90750 is reimbursable for recipients 60 years of age or older.

Zoster vaccine should not be administered to children, pregnant women, people with active tuberculosis, those who are receiving immunosuppressive therapy or those who are immunocompromised (for example, AIDS, leukemia, lymphomas).

Modifiers SA, SB, UD, U7 or 99 are allowed.

Claims must be billed “By Report.”

2017 HCPCS CHANGE CODES

Bolded Codes
Bolded codes indicate notation of special billing policy.

DME

E0140, E0149, E0197, E0955, E0967, E0985, E0995, E1020, E1028, E2206, E2220 – E2222, E2224, E2228, E2368 – E2370, E2375, K0015, K0019, K0037, K0042 – K0047, K0050 – K0052, K0069 – K0072, K0077, K0098

E0140
Walker, with trunk support, adjustable or fixed height, any type has an updated monthly rental price of $21.05 and purchase price of $210.55.

E0149
Walker, heavy duty, wheeled, rigid or folding, any type has an updated monthly rental price of $9.52 and purchase price of $95.27.

E0197
Air pressure pad for mattress, standard mattress length and width has an updated monthly rental price of $13.49 and purchase price of $134.96.

E0955
Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each has an updated monthly rental price of $13.36 and purchase price of $89.13.

E0967, E0995, E2206, E2220 – E2222, E2224, K0019, K0037, K0042 – K0047, K0050 – K0052, K0069, K0071 – K0072, K0077
These codes are no longer rental items and must be billed with modifiers NURB/RBNU. Documentation of the patient-owned equipment these accessories are applied to must be included in the *Additional Claim Information* field (Box 19) of the claim.

E0985
Wheelchair accessory, seat lift mechanism has an updated monthly rental price of $19.44 and purchase price of $129.60.

E1020
Residual limb support system for wheelchair, any type has an updated monthly rental price of $16.86 and purchase price of $112.40.

E1028
Wheelchair accessory, manual Swing-Away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory has an updated monthly rental price of $12.71 and purchase price of $84.73.

E2228
Manual wheelchair accessory, wheel braking system and lock, complete, each has an updated monthly rental price of $86.58 and purchase price of $577.26.

E2368
Power wheelchair component, drive wheel motor, replacement only is no longer a rental item and has an updated purchase price of $253.00.

E2369
Power wheelchair component, drive wheel gear box, replacement only is no longer a rental item and has an updated purchase price of $239.06.

E2370
Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only is no longer a rental item and has an updated purchase price of $328.79.

E2375
Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only is no longer a rental item and has an updated purchase price of $401.46.

K0015
Detachable, nonadjustable height armrest, replacement only is no longer a rental item and has an updated purchase price of $107.68.

K0070
Rear wheel assembly, complete, with solid tire, spokes or molded, each is no longer a rental item and has an updated purchase price of $97.39. This code must be billed with modifiers NURB/RBNU. Documentation of the patient-owned equipment these accessories are applied to must be included in the *Additional Claim Information* field (Box 19) of the claim.

K0098
Drive belt for power wheelchair, replacement only is no longer a rental item and has an updated purchase price of $24.83. This code must be billed with modifiers NURB/RBNU. Documentation of the patient-owned equipment these accessories are applied to must be included in the *Additional Claim Information* field (Box 19) of the claim.

Medicine

90846, 90847, **92235, 92240, 94060**

92235, 92240
CPT-4 codes 92235 and 92240 are no longer reimbursable with modifiers 50, LT or RT.

94060
CPT-4 code 94060 may be billed with any of the following Place of Service codes:

Place of Service Code	**Description**
1	Office
5	Outpatient Hospital
9	Clinic
A	Surgery Clinic
11	Office
22	Outpatient Hospital
24	Ambulatory Surgery Clinic
53	Community Mental Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

Pathology

81403

81403

The *Treatment Authorization Request* (TAR) criteria has been updated to include the following:

- Known family variant not otherwise specified, for gene listed in Tier 1 or Tier 2, or identified during a genomic sequencing procedure (GSP), DNA sequence analysis, each variant exon:
  - Documentation of the specific gene listed in Tier 1, Tier 2 or GSP for which further analysis is being requested

Physician Administered Drugs (PAD)

C9250

C9250

Claims must be billed “By Report.”

Radiology

74240, 74241, 74245–74247, 74250, 74251, 77078, 77778, 78264

74240, 74241, 74245–74247, 74250, 74251, 77778, 78264

The codes are split-billable and modifiers TC and 26 are allowed. When billing for both the professional and technical components, a modifier is neither required nor allowed.

2017 HCPCS DELETED CODES

Chemotherapy

Deleted Code
C9472
C9474
C9475
C9476
C9477
C9480
G3001

Dental Procedures

Deleted Code
D0290

DME

Deleted Code
B9000
E0628

Medicine

Deleted Code
92140
93965
97001 – 97006
99143 – 99145
99148 – 99150
99420
C9800
G0163
G0164
G8401
G8458
G8460
G8461
G8485 – G8467
G8489 – G9491
G8494
G8496 – G8500
G8544
G8545
G8548
G8549
G8551
G8634
G8645

Medicine (continued)

G8646
G8725
G8726
G8728
G8757 – G8759
G8761
G8762
G8765
G8784
G8848
G8853
G8868
G8898 – G8900
G8902
G8903
G8906
G8927 – G8929
G8940
G8948
G8953
G8977
G9203 – G9211
G9217
G9219
G9222
G9233 – G9238
G9244
G9245
G9324
G9435 – G9443
G9463 – G9467
G9499
G9572
G9581
G9619
G9650 – G9653
G9657
G9667
G9669 – G9673
G9677

Pathology

Deleted Code
80300 – 80304
81280 – 81282
G0477 – G0479

Physician Administered Drugs (PAD)

Deleted Code
C9121
C9470
C9471
C9473
C9478
C9479
C9481
J0760
J1590
Q9980
Q9981

P&O

Deleted Code
A4466
K0901
K0902

Radiology

Deleted Code
75791
75962
75964
75966
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Skin Substitutes and Podiatry

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Surgery

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